

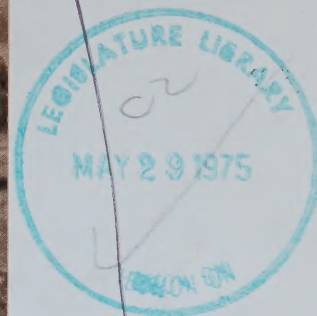
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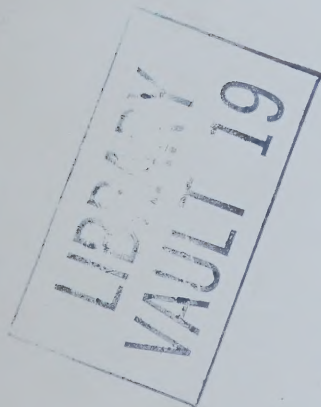
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Alcohol Use and Related Problems in Northern Alberta; a Discussion Paper. 2



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DISCUSSION PAPER



ALCOHOL USE AND RELATED PROBLEMS

IN NORTHERN ALBERTA

Alberta

NORTHERN DEVELOPMENT GROUP

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ALCOHOL USE AND RELATED PROBLEMS
IN NORTHERN ALBERTA



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*"I do not say it is good; I do not say it
is bad; I say it is the way it is"*

- Talleyrand

I. INTRODUCTION

A cartoon from "The Journal", a monthly newspaper published by the Addiction Research Foundation of Ontario, depicts a number of scientists about to heave a fellow member out of the upper storey window of a building. The reason: he claims to have the solution to the drug problem.

This paper does not proclaim any solutions. It presents the interpretation of one person who is concerned about alleviating some of the social ills caused directly or indirectly by the use of drugs.

This presentation is a general view of alcohol use, particularly among native people, based on a review of available scientific and unscientific literature, some personal observations, and contact with people involved in the treatment of and prevention of alcohol problems. Northern Alberta is the major area of concern, particularly Census Divisions 12, 13, 14 and 15.

Very little hard data seem to be available on just what the problem is in Northern Alberta. Drinking patterns, especially among native people in Northern Alberta, require long-range intensive study. Presently the approach to treatment and prevention is based on unverified assumptions and unreliable data. Until better data are compiled, approaches will continue to be "band-aid" in nature.

The major intent of this paper is to stimulate discussion and debate on the problems that arise from the use of alcohol. The purpose is to raise questions and perhaps to explore whether the questions now being asked are the right ones.

This paper deals primarily with the native population, with only general comments about the total drinking population. It will first look at some of the assumptions and theories associated with alcohol-related problems, second analyse the problem briefly, and third comment about research, social policy, treatment and prevention.

II. ALCOHOL

Before the various assumptions held about alcohol are discussed, a few introductory comments concerning that subject will be made.

Drinking alcohol is a generally accepted part of Canadian life. It is considered by most to be socially acceptable and by some as even necessary. It is used in all types of social settings: religious ceremonies, business contacts, family ritual, and recreational activities. For some, drinking alcohol is synonymous with having a "good time." Eighty (80%) percent of the adult population over 15 years of age consume alcohol.

The use of alcohol does not normally cause problems for the majority of the drinking population, nor for the rest of society except for those who view drinking as morally objectionable. It is, however, a social and personal problem for some people. It is estimated that five percent of the drinking population are alcoholics and ten percent are problem drinkers. (These figures do not apply to the native population, where it is estimated that the problem is much more serious.) The National Council on Alcoholism in the United States estimates that one out of twelve or fourteen social drinkers is an alcoholic. Alcohol is said to become a problem when its use causes "damage to the individual, society, or both." (Jellinek, 1960.)

Theories about the causes of alcoholism vary, with physiological, psychological and socio-cultural explanations being popular. The physiological approach says that alcoholism is related

to a biochemical factor which is usually assumed to be genetic. This theory is unacceptable to most theorists as it has not been scientifically demonstrated. (Keller, 1958.)

The psychological causes are said to be due to abnormal or poor personality development and emotional instability. The alcoholic is a person who suffers from a lack of self-worth, inadequacy, guilt feelings, insecurity and a number of other personality traits. Critics of this theory question whether there is an "alcoholic personality" shared by all alcoholics, since these same characteristics are found in social drinkers who do not become alcoholics. Also, in some people the emotional problems may be caused by alcohol. That psychological theories seem to predominate today is probably in part due to the large number of psychologists involved in alcohol research.

The socio-cultural explanations of alcoholism usually stress the social conditions, roles and customs that are prevalent among drinkers. The problems of tension and stress caused by urbanization, change, immigration or migration, affluence, poverty, ethnicity, and other factors are used to explain the use and problem use of alcohol.

A variety of prevention and treatment methods are advocated in dealing with alcohol problems, none of which claims complete success. A major difficulty in managing this problem is the lack of agreement concerning alcoholism and methods of treatment and prevention. Even the disease concept which has almost been considered an empirical fact is now being questioned (Larkin, 1974). The complexity of treatment and prevention is treated later on in this paper.

For a more detailed analysis of the effects of alcohol, prohibition, patterns of drinking and other notions, see Appendix

I.

III. ASSUMPTIONS

We all hold various assumptions about alcohol and drugs which influence our attitudes, approaches and decisions on whether we will or will not drink. These assumptions are generally not of the either/or variety, but are on a continuum which usually goes from the simple to the complex. The following will illustrate some of these assumptions and point out the complexities in dealing with this issue. These assumptions are based on particular biases and inferences.

1. Understanding Human Nature

Original Sin ----- Man is basically good

Behavior is relatively
uniform ----- It is complex

All men are the same ----- Individuals vary

2. Approaches to Life

Absolutism ----- Relativism

The absolutist believes that there is only one form, or an extremely limited number of forms, of behavior that is right and proper and that should be permitted. An example of this position would be to consider abstinence as proper and any form of drinking as improper. (Most sociologists believe that this approach prevents any meaningful understanding of human behavior.)

The relativist, on the other hand, accepts many ways to be human. What is right and acceptable for one culture is not necessarily true for other cultures, or even sub-cultures of the same culture. Behavior is not right or wrong in the abstract, but is labeled right or wrong within certain settings.

3. Drinking Patterns

Experimentation ----- Compulsive

Between experimentation and compulsive use of alcohol, other types are noticeable - recreational use, circumstantial use and intensified use. These terms are described in Appendix I.

4. Nature of the Problem

Drugs are the problem ----- Drugs are only a symptom of
basic social problems

This assumption will be explained more fully under theories of social problems.

5. Causes of Addiction

Biological ----- Labelling

At one end of the continuum are those who feel the cause of addiction is due to some biological chromosome structure of the individual which leads him/her to become an alcoholic. Some suggest that personality causes the deviance, others that the causes of addiction are social/cultural - poverty, ghettos, economic and social reasons. While at the other end of the continuum there are some sociologists who feel that much of what is known is a labelling problem. (More on labelling under theories of social problems.)

6. Treatment

Pharmaceutical ----- Religious

Treatment of alcoholism may involve replacing one drug

(alcohol) with another drug (valium, librium or antabuse), psychiatric therapy, intensive group therapy which may use drug or non-drug approaches, or religion, using religious institutions, a charismatic figure like the Guru Maraji, or some other variant of religion. Alcoholics Anonymous (A.A.) is at times looked upon as a religious approach or a therapeutic approach.

7. Prevention Goals

Abstinence ----- Indiscriminate use

Between abstinence and free, indiscriminate use are temperance (not necessarily abstinence), wise use of drugs, moderation and proper use. The assumptions we hold about human nature, approaches to life and nature of the drug problem will greatly influence our assumptions about the goals of prevention.

8. Techniques of Social Control

Enforcement of Strict

Drug Laws ----- Free use of drugs

Legal control assumptions can range from very strict enforcement, to low security methods, to toleration of social deviance, to taking the problem entirely out of the hands of the legal system.

As was noted at the beginning, these assumptions are just examples of those which relate to the approach that is taken in dealing with the alcohol issue. They point out the many various positions that people hold about the basic issues

related to drug problems. These assumptions will determine how the drug problem is defined, how it is treated and the related social policies and methods of prevention.

IV. THEORIES OF SOCIAL PROBLEMS

Since the misuse of alcohol is considered a social problem, it is important to discuss the theories or perspectives of social problems. Theories facilitate the organization of information and help in observing how facts and findings do or do not fit together.

It is questionable today whether any one particular theory is capable of dealing with all the diverse phenomena observed with respect to social problems. It is highly unlikely that any "grand theory" will be accepted by all social scientists. The present trend is toward the development of "mini-theories that seek to explain a narrower band of behavior or a more specific phenomenon." (Wrightsman, 1972.) Therefore it is recognized that the theories presented are not exhaustive and may have limited applicability as an explanation of the social behavior of drinking alcohol.

Rubington and Weinberg (1971) suggest five different perspectives or theories that are used by theorists in analysing social problems: social pathology, social disorganization, value conflict, deviant behavior and labelling. While each approach defines social problems somewhat differently, there is a significant consensus on (1) whether or not some particular phenomenon is a problem and (2) whether or not something should be done about it.

For social pathologists, social problems are a violation of moral expectation and emphasize the individual; social disorganization theories see change as a basic problem and stress the role of the person in society; deviant behavior theories concentrate on individuals or groups that deviate from established norms and stress their importance;

value conflict theories see social problems as conditions which are incompatible with societal or group values; labelling theories see social problems as arising from the subject defining the problem.

For sake of convenience and brevity, this paper will comment briefly on the "value conflict" and "labelling" approaches as they apply to alcohol problems. This is not to say that the other theories are not relevant to this study. Each theory has something valid to say about the causes of alcohol problems and the solutions offered.

Fuller and Meyers (Rubington & Weinberg, 1971) who are foremost in developing the value conflict approach, suggest a three-fold classification of social problems:

1. Physical Problems

All people agree that there is a problem and there is not much that can be done about it; for example, floods, earthquakes, etc.

2. Ameliorative Problems

Everyone agrees that the situation is undesirable, but they differ strongly about the solutions proposed; for example, poverty.

3. Moral Problems

There is no agreement among people that these situations are problems, nor among those who think they are, about how to solve them.

While recognizing that many people perceive a relationship between alcohol and safety (the use of it may increase aggressiveness, violent behavior, or traffic accidents), a relationship between alcohol and health and welfare (decreased social performance, family disruption, unemployment, cirrhosis and malnutrition), it is most often in the normative social order (values system and morality) that decisions are made on whether alcohol constitutes a social problem or not. "The Journal", (ARF, 1974) notes that Dr. M. Goodstadt, a research scientist with the Addiction Research Foundation, pointed out the wide range of perceptions that exists concerning the seriousness of the alcohol problem. Eighty-six percent of the staff at the Addiction Research Foundation cited alcohol as a problem, but only 4% of a sample of the general public agreed that it was a serious problem. This suggests that there is still little agreement as to whether or not the use of alcohol is a social problem. It may also suggest that those involved with the prevention and treatment of alcohol-related problems are unable to convince the general public of the seriousness of this issue, or perhaps that ARF personnel, who work with alcohol problems all the time, come to believe that the problem is more serious than it actually is. As such, then, alcohol use fits into the category of moral problems as defined above.

A contemporary theory in the study of behavior which is related to drug use is that of labelling, or the process of judging deviance in others. "Behavior is not right or wrong in the abstract, but is labelled right or wrong within certain settings by certain groups in society. Deviance, in other words, is manufactured, created

by human judgement. It is arbitrary, not natural." This theory is also referred to as "ethno-methodology" (Erich Goode, 1973).

"The only Indian is a drunk Indian," is an example of labelling by the non-native culture. This type of statement maintains the very behavior it condemns. When people expect an Indian to be drunk, they also expect him to act like a person intoxicated. After a time he comes to view himself as a deviant, which then becomes his normal way of acting. One native counsellor has suggested that even though an Indian is not intoxicated after drinking, because the white culture expects him to be drunk, he will therefore act as if intoxicated. "At the same time, when no label is applied, a deviant often may discontinue his deviance, without any change in his background or 'basic personality'." (Etzioni, 1972.)

A major criticism of the labelling model is that it describes secondary deviance, but it does not adequately analyze primary deviance (Levy and Kunitz, 1974).

This paper is more inclined to identify with this last "mini-theory" of social deviance or social problems while recognizing its limited applicability to the total issue.

V. NATIVE DRINKING

Before discussing the problems related to alcohol use in Northern Alberta, particularly among native people, a few random comments about native use of alcohol are considered.

From an examination of the literature, it would appear that there are distinctive patterns which separate the native and non-native drinking habits. The following generalizations are often made about native drinking patterns:

- Most natives drink to become intoxicated whereas most whites drink to some degree of moderation without becoming intoxicated. Native children normally see alcohol used only as an intoxicant, and thus learn this type of drinking behavior.
- Economic factors have a strong influence on native drinking patterns. Consumption increases greatly when money is plentiful and declines when it is not. Most natives drink in groups - peer or kinship types - and rarely drink alone.
- It is difficult to define Indian alcoholism according to the criteria normally used. Physical characteristics such as cirrhosis of the liver and the withdrawal syndrome are not common among so-called native alcoholics. These characteristics, however, are becoming more noticeable as native people become better off financially, and their drinking becomes more constant.

These few generalizations indicate that because of

dissimilarities between native and white drinking, a more diverse treatment and prevention approach may be required.

A. History

Although there are different historical descriptions of Indian drinking, the most commonly accepted theory delineates a three-fold period. (Daily, 1964; Dozier, 1966; MacAndrew & Edgerton, 1970; Levy & Kunitz, 1974.)

1. Alcohol, initially introduced by the white man*, was used by the Indian as an intoxicant in order to alter his consciousness, to attain "other-worldliness," or to transcend his self-image. He normally drank to get drunk, or until the supply was exhausted. It was also a time when the Indian could release aggression and not feel any guilt about the consequences.
2. The second period, which began early in the 19th Century, was characterized by considerable deculturation and deprivation. The Indian now drank to forget and to assist in coping with "the anxieties of a meaningless world." The drinking pattern was the same as previously, drinking to intoxication.
3. Few natives seem to be involved in the first period. The second period is still often used among native

*There were only two references which indicated any difference. A brochure published by Public Education, Bureau of Alcoholic Rehabilitation, Florida, that stated "At the time Columbus discovered America, the North America Indians were already drinking beer." MacAndrew & Edgerton (1970) also note that natives in the Southwestern part of the U.S.A. drank alcohol before contact with whites.

alcohol workers as the major cause of drinking among the Indian population. Historians and some social researchers, however, question this assumption. While a few still drink for this reason, it seems most drink as a source of recreation. Today the Indian drinks because he wants to, because he finds it pleasurable, and because he finds nothing wrong with it. And as in the previous two periods, he drinks to get drunk.

Many Indians look upon their drinking as a form of relaxation and recreation, and have little desire to eliminate such behavior.

B. Patterns of Drinking

Levy and Kunitz (1974) suggest four distinct patterns of drinking among natives:

1. "Male, Peer Group Binge Drinking"

This is the most commonly commented pattern observed in public places. It is usually a male group of approximately the same age and the style is the "binge" form.

2. "Family and Extended King Group Pattern"

It is probably here that young people learn a system of drinking which determines their drinking life style. It is also this pattern that generates the most serious problems to the native population.

Child neglect, wife beating, molesting and other family deviances may result from this type of drinking.

3. "Off-Reservation Pattern"

This type of pattern is where most of the labelling takes place by the white culture with such statements as, "The only Indian is a drunk Indian." It is difficult to determine between "long term town dwellers, urban transients and casual visitors from the reservation." Often it is a small minority of natives who are the "hell-raisers" and the stereotyping that takes place is unjustified. It is estimated in the town of Lac La Biche, where a sizeable native population resides, that 30 to 40 percent of the 999 arrests for intoxication in 1973 involved repeaters.

4. "Individual Drinker"

This type of pattern is considered rare and a deviate form of behavior among the natives. The individual involved is often socially isolated and is most likely typical of the average white alcoholic. Though still rare, this type is becoming more noticeable.

There is no strong evidence to support the theory that there are biological or racial differences which cause the native to be more susceptible to intoxication or alcoholism than other cultures

or races. It is more commonly held that the causes must be sought in historical, social and cultural factors.

E. P. Dozier (1966) feels that the major problem rests with the peer group, binge drinking or gang-type drinking, and not necessarily with the addicted drinker. Not many Indians would be considered alcoholics according to the WHO definition:

"Alcoholics are those excessive drinkers whose dependence upon alcohol has attained such a degree that it shows a noticeable mental disturbance, or an interference with their bodily or mental health, their interpersonal relations and their smooth social and economic functioning; or who show the prodromal sign of such developments."

Some Indians do fall into this category, the majority do not.

Rarely do such types raise a lot of hell -- it is the group or gang drinkers that generally cause trouble.

C. Summary

Very briefly the following comments summarize commonly-held beliefs about native drinking:

- Indians drink to become intoxicated
- drinking is a recreational form of behavior
- there is no stigma to being drunk
- children learn a type of drinking at an early age
- drinking is normally done in groups
- Indians drink until the supply is exhausted

- They drink because they like to drink; it is pleasurable and, contrary to popular opinion, it does provide positive as well as negative values
- facilitates conviviality in social setting
- promotes feeling of solidarity
- gives individual sense of power and fearlessness
- few Indians manifest the physiological damage that is characteristic of alcoholism as defined in white terms.

The above comments in no way minimize the problem of drinking among native people. They do, however, suggest that because Indian drinking habits are not like those of white people, the search for solutions is complicated. It is often suggested, and rightly so, that it would be wiser to examine the question of drinking among native people by considering patterns of drinking rather than alcoholism, and secondary rather than primary deviance.

VI. THE PROBLEM

This section will look at the alcohol related problems in Alberta and Northern Alberta in particular. The next section will comment on native alcohol problems.

A. General Characteristics

It is very difficult to measure directly the prevalence of problems caused by alcohol. Indirect measurements are usually based on convictions for drunkenness, hospital admission, alcohol sales data, and the causes of death which are entirely or partially related to alcohol - suicide, homicide, cirrhosis of the liver.

The attached chart (see Appendix II) taken from the Annual Report of the Addiction Research Foundation, Province of Ontario, 1971-72, gives a general picture of alcohol use in Canada, the incidence of related problems, and Alberta's position in the total picture.

Canada has a per capita (age 15 and over) alcohol consumption of 8.95 litres per year. This would be approximately 2.25 ounces of whiskey per day or the equivalent of 5.25 ounces of wine or 18 ounces of beer. The average Canadian must spend 2.9% of his annual personal disposable income to buy this stated amount. Between 1950 and 1967 Canadians increased their per capita consumption by close to 30%.

B. "Apparent" Alcohol Consumption in Alberta

(The following statistics are based on Ontario figures and are only "apparent" guesses of what the scene is like in Alberta.)

1. It is estimated that of the adult population over 15, 86% of males and 75% of females consume alcohol:

Total population over 15 (1971 census)	1,113,370	
Male population over 15		565,675
Female population over 15		548,695
Male drinkers (86%)		486,500
Female drinkers (75%)		411,500
Total drinkers		898,000

2. Alcohol sales for Alberta (1970-71)

Liquor	92,728,536
Beer	63,662,670
TOTAL	\$156,391,206

In 1970-71 the drinking population 15 years of age and over, spent approximately \$174 per capita on alcoholic beverages. (\$103 on liquor and \$71 on beer.)

3. Using Ontario estimates, 10.7% of all male drinkers and 2.7% of all female drinkers consume an average of at least 9 ounces of whiskey or its equivalent in beer and wine daily, and are thus considered "hazardous drinkers"; 5.2% of male drinkers and 1.4% of female drinkers consume an average of at least 13 ounces of whiskey or 32 ounces of wine or 104 ounces of beer daily, and are thus considered "alcoholics".

	<u>Male</u>	<u>Female</u>	<u>Total</u>
Drinking Population (1971)	486,500	411,500	898,000
Hazardous Drinkers - Percent	10.7	2.7	
Number	52,100	11,100	63,200
Alcoholics - Percent	5.2	1.4	
Number	25,300	5,800	31,100

The 63,200 "hazardous drinkers" account for 40% of the total sales value of alcohol in Alberta, that is, for total sales of \$62,556,000 or approximately \$990 per person in 1970/71. The 31,100 alcoholics provide 25% of the money spent, or \$39,093,000, or \$1,260 per person per year.

C. The Northern Region (Census Divisions 12, 13, 14 and 15)

1. Drinking Population

Total Population over 15 (1971 Census)	136,520
Male Population over 15	73,425
Female Population over 15	63,095
Male Drinkers (86%)	63,100
Female Drinkers (75%)	47,300
Total Drinkers	110,400

2. Alcohol Sales (1970-71)

Liquor	9,730,470
Beer	4,108,263
TOTAL	13,838,733

In 1970-71 the average drinker is estimated to have spent \$125 on alcoholic beverages, \$88 on liquor and \$37 on beer.

3. Alcoholics and Hazardous Drinkers

	<u>Male</u>	<u>Female</u>	<u>Total</u>
Drinking Population	63,100	47,300	110,400
Hazardous Drinkers - Percent	10.7	2.7	
Number	6,750	1,280	8,030
Alcoholics - Percent	5.2	1.4	
Number	3,280	660	3,940

The 8,030 "hazardous drinkers" account for about 40% of the total sales value of alcohol in Northern Alberta, that is, for total sales of \$5,535,000 or approximately \$690 per person in

1970-71. The 3,940 alcoholics provide 25% of the money spent, or \$3,460,000, or \$880 per person.

The above are only apparent figures based on the assumption that the consumption patterns in Alberta and Northern Alberta are similar to those in Ontario, and any conclusions drawn from them are tentative at best. It must be remembered that individual consumption of alcohol for any given population will vary from very small quantities to almost lethal amounts of alcohol. The patterns of use may vary in the north - binge type over social drinking; and the type of alcohol used may also vary - cheaper wines may be sold in the northern region. Other factors such as personal disposable income and the possibility that there may be more abstainers and more heavy drinkers may have to be considered. These, however, are only assumptions. About all we can say is that, from a comparison of data on sales and population, consumption of alcohol in the North seems to be no greater, but may perhaps be less, than in the rest of Alberta.

See Appendix III for a comparison of the alcohol sales in Northern Alberta and Alberta for the years 1970, 1971, 1972, and 1973.

D. Cirrhosis of the Liver

As noted, Canada has an annual alcohol consumption of 8.95 litres of absolute alcohol. There is a death rate from liver cirrhosis of 11.9 per 100,000 adults. In Alberta the death rate is 6.9 per 100,000 adults (Quarterly Statistical Review, 1973.) Finland, whose consumption rate is equal to half that of the average Canadian (4.16 litres) has a death rate of 5.4 per 100,000 from

cirrhosis. It is estimated that one out of every fifteen drinkers consumes a sufficient amount of alcohol annually to increase the risk factor of diseases such as liver cirrhosis.

According to a study by Ashraf Kayani of Health and Social Development, comparing fertility and mortality between Northern Alberta and the rest of Alberta, Northern Alberta has a lower mortality rate from the category which includes cirrhosis of the liver - diseases of the digestive system. Cirrhosis of the liver is ranked fourth in this classification in Northern Alberta, and first for the rest of Alberta.

E. Cancer

The Health, Education and Welfare Department in the United States recently suggested that the risk factor of cancer from heavy drinking could be comparable to that of smoking - heavy smokers who do not have a drink have a risk factor of 2.43 for oral cancer and for heavy drinkers who do not smoke, the risk factor is 2.33. For a person who drinks heavily and smokes heavily, it jumps to 15.50. (The Journal, 1974.)

F. Royal Canadian Mounted Police Statistics

The R.C.M.P. has two sub-divisions which handle the northern part of the province. The northwest section has its sub-division headquarters in Peace River, and the eastern section in Edmonton. The statistical department was able to give information on drug and specific alcohol offences, but they do not have files on alcohol-related incidents, e.g. theft, rape, assault and other criminal acts which may have resulted because of alcohol. The

R.C.M.P. stated that one should be careful drawing any hard conclusions based on drug files. There are factors which may make one sub-division or detachment more aware of drug use and thereby have more drug files than other detachments.

The statistics received are broken into alcohol offences related to Section 84 of the Alberta Liquor Control Act. This refers to offences of drunkenness where the individual is placed in jail overnight, but not necessarily brought to trial. (Some of the figures listed under the Section relate to other provincial offences where the accused did not appear in court, but virtually all are Section 84 offences.) The other statistics deal with cannabis (marijuana and hashish) unless otherwise stated. Controlled drugs refer to legal drugs - barbiturates, tranquilizers, amphetamines, etc. - which are used for illegal purposes. Restricted drugs refers to illegal drugs - L.S.D., M.D.A., etc. Opiates (heroin, methadone, morphine, cocaine, etc.) are listed as such.

- It is possible to generalize the following from these statistics:
- opiate use in Northern Alberta is not indicated.
 - controlled and restricted drugs do not appear to be very prevalent.
 - Cannabis (marijuana and hashish) is on the upswing in Northern Alberta as in other parts of the province.
 - offences against the Liquor Control Act appear to be higher in certain regions, e.g. High Level, High Prairie, Lac La Biche, Bonnyville and St. Paul, than other regions of Northern Alberta.

There may be other variables which have to be analysed before drawing hard conclusions regarding these areas. Often it is a "revolving door" problem, in that the prevalence of repeaters distorts the total number. Also, the R.C.M.P. may enforce this Act more

strictly in one area than another.

Further analysis of R.C.M.P. data will be carried out at a later date.

DRUG OFFENCES IN NORTHERN ALBERTA

	Opiates	Cannabis	Controlled	Restricted	84LCA
Peace River Subdivision	January 1 to August 31, 1974				
Slave Lake Det.	-	3	1	1	16
Slave Lake Mun.	-	6	-	3	143
High Prairie Det.	-	1	1	-	38
High Prairie Mun.	-	6	1	1	413
High Level Det.	-	2	-	1	30
High Level Mun.	-	6	-	1	392
Peace River Det.	-	6	-	-	-
Peace River Mun.	-	19	-	1	202
Grande Prairie Det.	-	13	-	-	6
Grande Prairie Mun.	-	85	1	9	523

Edmonton Subdivision	January - July, 1974				May 1973 to June 1974
Grande Cache Det.	-	2	-	-	1
Grande Cache Mun.	-	4	-	-	44
Ft. McMurray Det.	-	8	-	-	6*
Ft. McMurray Mun.	-	14	1	1	527*
Lac La Biche Det.	-	1	-	-	4
Lac La Biche Mun.	-	2	-	-	781
Bonnyville Det.	-	-	-	-	39
Bonnyville Mun.	-	3	-	-	154
St. Paul Det.	-	2	1	-	260
St. Paul Mun.	-	3	-	1	534
Cold Lake Det.**	-	8	-	-	59
Cold Lake Mun.**	-	3	-	-	137
Redwater	-	3	1	-	20
Fort Chipewyan	-	2	-	-	37

*Section 84 for Fort McMurray is from July 1973 to August 1974.

**Cold Lake (Grande Centre)

VII. ALCOHOL AS A PROBLEM FOR NATIVE PEOPLE

Although it may be difficult to determine whether or not an Indian person has alcoholism as defined according to white man terminology, it seems fairly well documented that the use of alcohol is the direct or indirect cause of other social problems.

Accidental deaths for native people in Alberta are said to be four times higher than for the non-native population; suicides are estimated to be three times that of white people, and homicides are said to be thirty times greater. Native people constitute 50% to 85% of the jail population. All these high incidences are said to be primarily caused by alcohol. The resultant cost in health and welfare services and in maintenance of jails and courts is no doubt astronomical. William Wacko stated that it costs \$12,000 a year to keep a man in jail for one year. It is estimated that it costs \$38 a day for the treatment of alcoholics at Henwood.

The Alcohol and Drug Abuse Commission's Research Department recently stated that it "is clear that serious problems related to the use of beverage alcohol do exist among the native people of Alberta." A random survey of an Indian reserve in Northern Alberta indicates 58% of the persons ranging in age from 16 to 78 said they drank; 29.5% answered "yes" to the question, "is drinking a problem for you?"; and 68% felt the drinking of others was a worry to them. (William Wacko, 1973, 1974.)

In order to be as objective as possible, some caution should be noted concerning alcohol related problems. There are some studies that indicate that child neglect, debauchery, crime, homicide and

suicide are not necessarily all due to alcoholism. This would be scapegoating other social deviances that exist. Levy and Kunitz (1974) go so far as to state that "neither increased acculturation nor increased alcohol use have been the major factors influencing these types of social deviance." Solving the alcohol problem does not necessarily mean a solution to the above social/medical problems.

Some Random Alberta Statistics

The native people account for less than 5% of Alberta's population. They averaged over a period of time 53% of all persons in detention. It is estimated that the majority of criminal offences are due to such social offences as drunkenness.

"Of all deaths since July 1953 (recorded), the percentage of alcohol-related deaths is 18.5%. There is a noticeable increase in alcohol-related deaths since 1969. It is interesting to note that of the one hundred and seven deaths since 1969, 39.25% are alcohol-related deaths."

*Native Counselling Services
of Alberta, 1973.*

It is estimated that the life expectancy of the native alcoholic is 30-40 years less than the national average.

Alcohol-related problems among the natives are said to be 10-15 times the national average.

Data from AADAC indicates that three-quarters of the adult Treaty Indian population have problems associated with alcohol abuse. (Native Alcoholism Programs, 1974)

VIII. INTEGRATED APPROACH

In order to combat the problems of alcohol it is generally agreed that a comprehensive approach is necessary, involving basically a combination of research, education, legislation and treatment. In theory most drug/alcohol-related agencies perform these four major functions. In practise, due to the size of the problem, insufficient public support and a lack of government funds, most of the emphasis is normally directed in the area of treatment. From a pragmatic perspective, this approach may seem the wisest, but is not adequate for a comprehensive solution. Alone none of these areas will do much to alleviate the problem; their combined application may help. A major difficulty is that specialists involved in one particular area, be it treatment, research, or prevention, have a tendency to believe that their approach is the whole answer, rather than only part of the solution. Since most of the personnel, supervisory and otherwise, of most alcohol-related agencies are oriented towards treatment, other areas are often just tolerated. While these agencies may respond that their programme includes education, research and enforcement departments, an examination of funding, personnel, and overall support indicates minimal direct effort in these areas.

Applying just a treatment model is like mopping up an overflowing bathtub without turning off the water. Yet this seems to be what most agencies are doing. This seems to be also true of the native alcohol agencies that are springing up in Alberta. One of the leaders in the treatment of natives stated that "treatment is the best prevention." There is no evidence to support such a claim. It must be pointed out,

however, that treatment for the native counsellors includes more prevention than the non-native treatment approach.

A basic assumption of this paper is that until more funding and resources are directed towards prevention, research and social policy, we will continue just to mop up the floor. This is not to say that treatment is unimportant, but that where the major direction is treatment, the limitations of such a model should be considered. Levy and Kunitz (1974) state that most of the individuals (Navajo Indians) who decided to stop drinking were able to do so "regardless of whether they were in a treatment program and whether intensive follow-up treatment was provided."

A. Research

"The primary role of science in the area of the non-medical use of drugs is to provide information to better enable individuals and society to make informed and discriminating decisions regarding the availability and use of particular drugs, and the appropriate responses to such use." (Le Dain, 1973)

A major difficulty in analysing the native drinking problem is that much of the research is plain guess work and based on unscientific methods. Another is that gathering data among Indian people is very difficult and analysts tend to interpret the available data so as to support their particular position. Very often the interpretation is biased and statistics are used to prove that there is a problem or that a problem does not exist.

"Research is just the beginning of any effort to control drugs." Today people are skeptical of so-called factual information about alcohol, especially when it does not correspond with experiential behavior. People will not accept old wives' tales about drugs. Research is required to provide the data necessary to make informed decisions about drugs.

Amitai Etzioni, professor of sociology at Columbia University, commented in the periodical "Evaluation" (1972) that what is needed is to increase our research efforts. We just do not have the basic knowledge necessary to treat alcoholics. The great expenditures laid out for treatment only give the illusion of doing something about the problem when the results are "painfully small."

"Applied social reserach should be more concentrated, more co-ordinated, more guided, and there should be direct ties between the researchers studying a particular problem and the agencies seeking to solve

it. But to invest resources in action programs is to squander them in those areas where we are as yet basically blind."

Evaluation, 1974.

Research is needed on the totality of addiction: the severity of the problem and the effectiveness of treatment models and of prevention programs. In particular there is a need for longitudinal research in analysing these areas.

Alberta Alcohol and Drug Abuse Commission Research

At the present time it is estimated that two and one-half percent of the annual AADAC budget goes into research. The research director indicates that with the present limited staff it is only possible to do research to evaluate programmes. Some exploratory research has been undertaken but not enough in the direction of primary and secondary influences or causes.

Some funding agencies, particularly government, hesitate to provide money in areas where only soft data exist to justify such expenditures. If alcohol and other drugs are thought to be causing serious medical and social damage then these assumptions should be researched and hard data obtained in order to use funds most effectively to alleviate the problem.

In the author's opinion there is a credibility gap between the scientific researchers and the practitioners of treatment. Researchers have a tendency to be born skeptics and question everything done in this field. They also frequently communicate in a language unintelligible to the general public. Treatment people, on the other

hand, because of the low success rate, are very sensitive to any criticism of their model and have a tendency to be over-protective of justifying the continuation of such a method.

B. Treatment

There is a cartoon depicting a native alcoholic counsellor talking to an inebriated male who is almost wrapped around a lamp post: "Don't you know that alcoholism is a disease?" The drunk replies, "I hope it is incurable."

The area of treatment for alcohol-related problems is as complex and controversial as other aspects of this issue. The model used will often depend on the assumptions held about the problem, about human nature and about the goals of prevention. Some may look for a total cure of the problem. Some aim at management of the problem, at bringing it under control. Others take a pessimistic attitude that nothing can be done for an alcoholic. The approach may be Alcoholics Anonymous (A.A.) or controlled drinking or the substitution of another drug.

To date the success rate of treatment programs has been quite low. While some, for instance A.A., appear to be more successful than others, at the very best they reach only a small percentage of problem drinkers. It is estimated that only 6% of the alcoholics in a community seek the help of A.A. (Developing Community Services for Alcoholics: Some Beginning Principles, 1972.) There are some native treatment models which are claiming a much better success rate than non-native models. It would seem, however, too early to evaluate such programs properly.

To complicate the problem, Levy and Kunitz (1974), as noted earlier, state:

"It is important, however, that most of the individuals in this study who did become aware alcoholic consumption is more costly than it is worth, were apparently able to stop drinking with little difficulty, regardless of whether they were in a treatment program and whether intensive follow-up treatment was provided."

The Le Dain Commission report suggests that unjustified expectations for treatment should be avoided. It is wiser to be pessimistic than optimistic in this area.

The majority of the treatment models available today are those which isolate the alcoholic from the community during initial stages and then proceed through a re-structuring or re-entering approach to assist him back into the community.

There is another school of thought which emphasizes the integrated community approach. Alcohol addiction is not seen as a chemical problem, but a problem of human behavior. (E.J. Larkin, 1974) Whereas the above stresses the medical model, this stresses the social/cultural model. Few (estimates run between 5% and 20%) alcoholics require medical services of a physician; what they need is a sense of self-worth and support to curb their drinking. Rather than having distinctive alcohol treatment centres, this approach would suggest that a community health centre could provide the necessary treatment. (Developing Community Services for Alcoholics: Some Beginning Principles, 1972)

A disadvantage of the first treatment model is that it becomes so specialized that communities, particularly northern ones, feel that only a specialist or personnel from AADAC can do any treatment. Most communities in the north have some professionals or

para-professional types working in other human service areas who could provide sufficient treatment to meet the problems related to alcohol. Many hospitals are today becoming more willing to supply detoxification beds. Most areas have workers who are acquainted with some of the modern counselling techniques that have some success with some alcoholics. AADAC also runs programs that will assist such communities to utilize local resources.

A criticism of the second model would be that the "non-alcohol expert" might possibly do more harm than good in assisting the alcoholic. Also, the alcoholic may need intensive therapy that cannot be provided by out-patient therapy.

Since AADAC's budget is too limited to provide specialized services throughout the north, some adaptation of the community model seems to be the only alternative suitable.

The ideal treatment model would consist of a pluralist approach where various structures are tried and techniques that range from controlled drinking to transcendental meditation. Since few, if any, treatment models can guarantee success it seems unrealistic to design or develop single treatment models. What is needed is imaginative experimentation.

Native Treatment

At the present time in Alberta the native people who are involved with the treating of Indian alcoholics are convinced that only a native-run treatment model will have any success with their people. The basic failure of the white man's model is that it does not communicate properly to native people and the facilities are in a foreign milieu. (Native Alcoholism Programs, 1974)

The research examined seems to support the above position. Before attempting any treatment or rehabilitation the specific role alcohol plays for each culture group has to be determined. In many instances this has not been done by white treatment models. It might also be questioned whether the native workers have done this in relation to their own people. It seems most of the native alcohol workers are A.A. oriented and as a result their perception of the problem is seen much differently from some natives not involved in this work. Native alcohol workers tend to blame all the ills of their people on alcohol. This, as noted earlier, is an oversimplification; it has to be questioned whether the major reason for the native problem is due to deculturation or exploitation or because they drink because they like to drink. We have no evidence, either, which indicates that economic and social development will solve the problem. North American society has developed greatly, but so has alcohol consumption along with alcohol-related problems.

While many of the native workers identify with an abstinence approach and are quasi-A.A. types, their treatment model is more of a social-cultural model than medical or legal. So far it

appears to be quite successful. Poundmakers' Lodge estimates a success rate of 47% (December 1974). Since it is too early in the game to draw hard conclusions from this success, their programmes should be continually evaluated. Part of this success seems to be that they are attempting a cultural identification in their model which has social/cultural/religious overtones.

A.A. does not seem to be very acceptable among native people. The reason suggested is the emphasis on admitting personal weakness and the religious overtones. Success is only noticed among those natives who have been acculturated. The native treatment personnel, however, do support the sobriety philosophy and support system of A.A.

The all-native approach does present difficulties for the funding agencies. Since there is some variance between the scientific field and the practical native counsellor this tension is inevitable. The positions taken range from "it is an Indian rip-off" to "give them all the money they want. We've wasted enough on unsuccessful programs. Why shouldn't they be given the same opportunity." Because of the cultural and religious implications of the native approach, the government offices are somewhat skeptical of what they are doing. However, the success rate, as noted above, seems to be so high that it is difficult to quarrel with their model of treatment.

Most of the literature reviewed supports the native people handling their own programs. The agreement disappears, however, when setting priorities of treatment, prevention, enforcement and research. In the native programs observed, the priority is definitely treatment. This approach should be questioned if it is true, as generally believed,

that the Indian drinker does not normally demonstrate the usual white symptoms of alcoholism. This is an area where more objectivity and debate are required by the native alcohol workers. If, as much of the research seems to indicate, the problem is to provide alternatives to drinking bouts or possibly alternate drinking patterns, the emphasis should be on prevention and social policy, and not treatment.

Treatment Facilities in Northern Alberta

As of December 1974, AADAC has offices located in seven northern centres (Appendix IV). The primary role of these offices is to provide community support in treating and preventing problems related to alcohol/drug abuse in surrounding areas. Because of a lack of personnel which is due primarily to a limited budget, all that is possible is a type of crisis intervention. Other northern communities have requested AADAC staff but presently have to get by on existing programs.

AADAC funds the following native programs in Northern Alberta:

- (1) Alexis - counselling service consisting of treatment counselling, education programs, and acts as a liaison with social service agencies in the area.
- (2) Bonnyville - counselling plus treatment operation.
- (3) Saddle Lake - drop in counselling service.
- (4) SPUTINOW - counselling services comparable to Alexis.
- (5) Kehewin - same as Alexis.

Poundmaker Lodge in Edmonton, a treatment facility, serves the native population in northern Alberta. Also, the Nechi Institute on Drug Abuse in Edmonton provides counsellor training for the native people.

Other agencies listed in William Wacko's report (1973, 1974)
as providing treatment in the north are:

Action North Recovery Centre
High Level - a rehabilitation centre

Frog Lake Counselling Services
Frog Lake

Cold Lake & Grand **Centre** Drop In Centre
Grand **Centre**

LeGoff Drop In Centre
Beaver Crossing

Saddle Lake Drop In Centre
St. Paul.

C. Prevention

Prevention programs depend on the goals established. Since these goals will vary according to the target group they are attempting to reach, they will vary greatly. Much will depend on the assumptions noted earlier on whether the goal is abstinence or moderation or something else. It is generally agreed that most programs fail. One of the major reasons for this failure may be that the goal is usually total abstinence. Since alcohol use is acceptable by the vast majority of the population, be it native or non-native, this goal is unrealistic.

The traditional prevention program has been instructional, usually through films followed by discussion. It is thought that once an individual has enough information, usually about the evils of alcohol, he or she will then make a responsible decision regarding the use of alcohol or another drug. Because this method does little in the way of examining feelings, emotions and behavior, it does little to influence a person. This is not to say that information is unnecessary. It is, however, only one part of the total program. It would be safe to say that most of the programs sponsored by alcohol-related agencies, schools, civic groups and others are still just imparting information.

Drug experts today suggest that the aim of prevention models should be to stress the necessary skills for coping with the problems of living and that the information about the drugs be but a minor part of the overall program.

The following areas seem to be the major components that should be part of any prevention program adapted to the different target population:

1. Developing a favourable self-concept, self-worth.
2. Interpersonal awareness.
3. Communication skills.
4. Developing a sense of one's own values - value clarification.
5. Decision-making skills or problem solving techniques.
6. Understanding social interaction - role or risks and peer pressure.
7. Information about drugs and alcohol.
8. Examination of alternate life style.

The above areas stress more the healthy development of an individual and only include information about drugs as one component. The implementation of this type of program requires the training of personnel in schools, homes and in the community. So far, northern Alberta suffers from a lack of competent people to utilize such a program.

This type of program emphasizes the importance of the freedom of the individual to make responsible choices.

A prevention program which has the above ingredients requires not only implementation on a school level, but also within the whole community. Too often such programs are left to the educational institution while other institutions are modelling exactly the reverse types of thinking and behavior.

This is a gigantic task. So far there has been little evaluation of such a prevention program. Some even question if it can be scientifically evaluated because it relates so much to values. But it is the approach suggested by most drug experts.

Once again a variety of approaches should be tried. Some are even suggesting traditional methods. Dr. Forrest S. Tennant, Jr. suggests that if we want to help children to avoid drug and alcohol problems we "should spank them occasionally, send them to church, and not let them drink alcohol until they are at least 15 years old." (The Journal, 1974.)

The Le Dain Commission Report (1973) suggests that a variety of strategies must be examined and used. More viable substitutes and alternatives have to be offered. The report states that we must also attempt to come to some consensus about motivation and other related factors which influence the causes of non-medical use of drugs.

Native Prevention Programs

Since the problem among the native people is so massive their programs are primarily treatment oriented. The prevention programs noted seem to follow the traditional show-a-film-and-discuss-it pattern. This approach is probably more questionable among the native people than the whites because there are so few native films in this area that are considered to be of much value.

On the other hand the cultural and spiritual revolution that is taking place among some native people does much to develop self-worth and self-respect, which is probably a much better prevention program than the drug educators' approach. Some counsellors seem to be moving in this direction.

Also, the program co-ordinator for Nechi Institute says that areas of training for native counsellors stress the very components suggested earlier for a good prevention program.

In a society that stresses "quickie" solutions to complex problems there is little room for optimism. Natives cannot be expected to change overnight.

Before a prevention program can be of any value, the Indian people will have to realize that the alternatives offered are much more valuable than that of alcohol. So far these alternatives have not been attractive enough to produce any change.

D. Social Policy

"The objective of policy and action should be to make the people better qualified to make free choices and to increase the choices open to them." (D. R. Hunter, 1968)

One of the first issues that arise when looking at social policy is the question of prohibition.

Prohibition is usually considered a disastrous approach to solving the alcohol problem. It didn't work with alcohol, nor is it working with marijuana or heroin. It is felt that all it does is raise prices and create a greater black market. The rise of syndicated crime in the United States is attributable to prohibition there in the 'twenties and 'thirties. Prohibition was recently tried in the Northwest Territories with a native tribe. The alcohol sales did not decrease, but there were fewer members who said they belonged to that particular tribe.

Dr. P. H. Blachly suggests that prohibition can be effective and useful but only under specific conditions.

"Prohibition is effective:

- a) when there is great public support for it;*
- b) when the prescribed behavior represents a clear and present danger;*
- c) when that which is prohibited is easily identifiable;*
- d) when the prohibited substance requires great technical skill and expense to produce;*
- e) when there is little profit in the substance or behavior;*
- f) when there is no romance in the prohibited substance or behavior.*

Prohibition is ineffective to the extent that these conditions are not met."

P. H. Blachly, 1969.

Prohibition therefore seems an unlikely legal approach, even among the natives. "Ban alcohol" is just not a viable solution to the Indian problem.

The Le Dain Commission (1973) stated that "non-medical drug use is too deeply rooted and too pervasive to be eliminated entirely." It is believed that no society has successfully eliminated drug use altogether. In primitive and well controlled small communities social control seems to be somewhat successful because the use has been institutionalized and ritualized. In mass societies, however, where social control has been passed from the home and church to educational and government institutions, the task of any social policy is very difficult because of the diversity of values and approaches to the issue by these various institutions. It is doubtful whether society as a whole would accept stricter and harsher laws regarding alcohol.

One of the better plans developed regarding social policy is the "Proposal for a Comprehensive Health Oriented Alcohol Control Policy in Ontario" (1973) by the Addiction Research Foundation.

This policy is based on the equation that as society consumes more and more alcohol the health related problems also increase. So far there is not a country where this equation has proven wrong. As already noted, alcohol consumption has increased measurably over the years in Canada and Alberta.

Two factors have been shown to be of major importance:

"(1) the relative cost of alcohol, and (2) the level of acceptance of drinking in a population." Regarding number (1), it is noted that the cost of alcohol and the individual's ability to pay are

"closely associated with the rates of alcohol consumption and alcohol problems. Where the price is low there are usually high consumption rates and related health problems. There is no incidence where the opposite is not also true: where prices are high, there is less consumption and fewer health problems." (ARF, 1973)

In Canada the relative price of alcohol has declined steadily and problems have increased. Between 1949 and 1974, in Alberta the price of alcohol and tobacco (these are combined in the consumer price index data) increased 60% while per capita personal disposable income rose 312%.

In countries where there is a very high acceptance of alcohol use - legal controls nil, low taxation, daily drinking patterns - there are high levels of consumption and high incidence of alcohol problems. The exception is Ireland where, however, there is a high price factor. In significantly dry countries the opposite occurs. The level of consumption and incidence of problems are relatively low.

Since prohibition and high prices are politically unrealistic and also ignore the social and psychological benefits that arise from moderation, the alternative is one which would aim at further decreases in alcohol-related problems. This would require:

"1. A taxation policy such that a reasonably constant relationship is maintained between the price of alcohol and levels of disposable (after taxes) income in the Province, e.g. if disposable per capita income rose 5% in a year, then the price of each alcoholic beverage offered for sale would be increased by that percentage.

2. A moratorium on further relaxation of alcohol control measures and the adoption of a health-oriented policy with respect to such measure. An important question to be asked is, are the proposed changes likely to contribute to high consumption levels and therefore to an increase in health costs? For example, the lowering of the drinking age from 21 to 19 has increased the alcohol-related problems in this age group.
3. A rigorous education program designed to increase public awareness of the personal hazards of heavy alcoholic consumption, the economic and other consequences for society of high consumption levels and the potential public health benefits of appropriate control measures. Special emphasis would also be placed on the social values of moderate drinking, the fallacies in contemporary models of 'civilized drinking;' and the character of safe drinking styles." (ARF, 1973)

The question legislators must ask is whether to risk in favour of public health by enacting such a policy or to take a chance on further social cost to society.

Native Social Policy

In the area of alcohol use, Indians will have to determine their own controls that are necessary for social stability. There is no indication that prohibition will work for them. The immediate task would be examining methods of built-in controls to internalize a system of moderate use. It is difficult to say whether the Ontario proposal would work for the native problem.

IX. CONCLUSION

As noted at the beginning, this paper is a general view of the problems of alcohol in Northern Alberta. Its purpose is to raise a few questions which will facilitate discussion on ways and means to come to grips with alcohol-related problems.

This paper has dealt primarily with the drug alcohol. There are some indications that other drugs, in particular marijuana, are increasing in use in Northern Alberta. Without underestimating the possible dangers of some of the other drugs, the economic, social and mental problems compared to those of alcohol are now minimal.

The major area of concern is among native people. Even if only half of what is said comes from hard data, the problem is of a serious nature. So far little has been accomplished. The bright light on the horizon is that there are competent native people who are attempting to attack this issue.

A significant number of native communities are beginning to attempt programs that will in some way alleviate alcohol-related problems. Native treatment facilities and counsellor training centres are now in operation which are controlled and managed by natives. Since the financing of these operations is primarily by the Provincial Government, it is important to stress that early indications are that these programs are realizing some success. While government agencies are normally skeptical of financing non-government controlled organizations, it is an assumption of this paper that the funding of native alcohol programs does much more than attempt solving alcohol problems. It also provides employment for natives, a sense of dignity in helping themselves

and an opportunity to retain their cultural heritage.

This paper has also looked generally at alcohol use in northern Alberta. As suggested, more attempts have to be made at utilizing existing community health and social services. Also the approach to alcohol problems must be much more than treatment-oriented and include a comprehensive program of research, treatment, prevention and social policy. This means that the present agency responsible for this field, AADAC, will have to be given more financial support.

Since the government is the sole distributor of alcohol, it must assume the major responsibility of controlling the problems which may result directly or indirectly. The net profits from alcohol sales last year (1973 report) were approximately 74 million dollars. The conservative estimated costs of treating alcohol-related problems within mental institutions, hospitals, child welfare, and others would be almost half this figure, circa 30 million dollars (based on a comparative cost analysis used in the Province of Ontario) not including physician fees, municipal welfare payments, cost of traffic accidents, nor loss to business and industry. At present AADAC's budget is around \$3 million, and most of this budget, approximately 85%, goes to treatment. These data suggest that considerable savings could result if more money were spent on enforcement, prevention and treatment supported by research.

A basic premise of this paper is pluralism. The approaches to treatment and prevention must be diverse. The Final Report of the Commission of Inquiry into the Non-Medical Use of Drugs (1973) states that we must avoid a commitment to any one response; just as people differ, so must our approaches to treatment and prevention.

There is no room in the field for monolithic responses. Variety and flexibility should be the watchwords. We have to leave room for a great variety of human intervention and relationships - in a word, for the personal touch. We have to leave sufficient room for flexibility within our institutional arrangement for the creative play of the human spirit.

(Le Dain, 1973)

The problem of alcoholism is a complex issue. There are no simple approaches and there is no one ideal treatment or prevention model that will alleviate the problem. There are limitations to all approaches. There are basic philosophical differences concerning the quality of life, the nature of survival in a complex society, "straight" versus "stoned" thinking, that are directly or indirectly related to the drug issue. Public and private agencies all have their biases and prejudices which influence the type of program preferred, the relative priorities of treatment and prevention. In the final analysis a particular program will be accepted or rejected because of the assumptions we hold. It is not always a question of right or wrong, but rather which alternative will best fit our assumptions, and which approach will best meet the needs of the people at a particular time in a particular place.

"There is always an easy solution to every problem - neat, plausible and wrong."

X. RECOMMENDATIONS

This paper is not geared to make recommendations but primarily, as noted, to raise questions for discussion. However, the following may generate some thought for some priorities that may be considered.

The attached recommendations (Appendix V) made by the late William Wacko, consultant on alcohol with the Federal Department of Indian Affairs and Northern Development, should also be given consideration.

A. Research

1. AADAC should be allotted more funding for research.
2. Exploratory research should be undertaken in the native communities to test the hypothesis that they do not suffer from alcoholism as defined generally in white man's terms (Jellinek) but from a social/cultural pattern that requires different treatment and prevention models.
3. Greater evaluative research of preventive and treatment models in northern Alberta.
4. A better co-ordinated or integrated method of collecting data be devised between such agencies as Attorney General, Solicitor General, AADAC, R.C.M.P. and Health Department, etc.
5. Research material be written in such a way so that it is easily interpreted by people in the field.
6. Northern Development Group continue to evaluate, monitor and research this problem in northern Alberta.

B. Treatment

1. More varied approaches of treatment models be experimented with in northern Alberta, particularly among the native people, from Indian spiritualism to controlled drinking.

2. Community integrated treatment models be established where AADAC is unable to provide specialized personnel. (Utilizing existing social-medical services with consultation provided by AADAC.)
3. More monies be available to AADAC and communities for the treatment of alcohol-related problems in northern Alberta.

C. Prevention

1. More monies be made available for prevention programs that provide alternatives to drinking and drug use.
2. Social Services and Community Health provide more public health educators in northern Alberta to promote mental health.
3. The Department of Education provide more competent counsellors in northern education districts to promote primary and secondary prevention.
4. AADAC Research Department attempt to evaluate prevention programs in northern Alberta on a continuing basis.
5. More seed money be made available to native organizations that are involved in the promotion of Indian identity.

D. Social Policy

1. The Alberta Government promote a public health policy supportive of that suggested in this paper by the Ontario Health Department.
2. The Alberta Liquor Control Board be more involved in social policy and preventive programs (compared to the work of the Manitoba Board in its relationship with the Manitoba Indians.)
3. Those involved in decision making regarding social policy - the courts, police, medical services, government organizations, etc. - be better informed of scientific findings in this area, and be made more aware of assumptions held by various groups.

APPENDIX I

GENERAL NOTIONS ABOUT ALCOHOL

*Adapted from "The Interim Report of the
Commission of Inquiry Into the Non-
Medical Use of Drugs" - Chapters 2 & 3.*

Alcohol is one of the most widely used psychoactive drugs known to man and its use dates back to the earliest recorded history of the human race. The use of alcohol has appeared in varying degrees in most societies throughout recorded history and has traditionally played an important symbolic as well as pharmacological role in many social, religious and medical practices and customs. Just as the use of alcohol has been universal, so apparently has its misuse. Consequently, some degree of opposition to 'drink' appears to have arisen in all indulging cultures, although attempts to eradicate its use have met with a uniform lack of success.

Along with tobacco, alcohol remains, at least in the Western culture, the most popular and widely-used of the legitimately-manufactured drugs. While it is probably most often taken to alter mood, it is also used, unlike the tranquilizers and amphetamines, for other reasons. Its use is so accepted in our society that few Canadians seem willing to recognize and accept it as a drug, although alcohol abuse clearly presents the most serious and widespread drug problem in Canada. "In the terms of medical pathology, alcohol is the most dangerous drug consumed routinely by a large number of people; it is more dangerous, by far, than heroin for instance."
(E. Goode, 1973)

A. Prohibition

Canada has experimented with alcohol prohibition in varying ways since 1878. Although there are currently some 'dry' localities, alcohol is generally legally available across the country. An interesting aspect of drug history is connected with alcohol laws: over 300 years ago the prohibition of liquor sales to Indians was Canada's first alcohol regulation. Some such discriminatory policies are only now being eliminated.

The failure of prohibition in the U.S.A. has been attributed to the unworkable form of the laws, inadequate enforcement, corruption among public authorities and perhaps most importantly, a general lack of public support. The prohibition resulted in bootlegging and smuggling which was rapidly taken over by organized crime. Some authorities believe that this multi-million dollar illicit market provided the impetus for the economic and political strength of syndicated crime in North America.

B. Today

Alcohol is now used by more than three-quarters of the Canadian population over the age of 15. There are many long-standing customs, traditions and superstitions which pervade alcohol use in the Western world. Because it has become an integral part of our culture, the set and setting surrounding alcohol use is substantially different from that associated with other drugs in Canada.

Alcohol may have special meanings in various social contexts. Alcohol use is often symbolically and pharmacologically associated with the acknowledgement of birth, death, marriage and other contracts, adulthood, friendship and to some, it may imply virility and masculinity. Although it is employed in some religious ceremonies, many individuals have moral apprehensions about alcohol and may approach its use with feelings of ambivalence and guilt. Some reject it outright on grounds of principle, while still others feel that moderate use is morally acceptable. In many social circles abstinence is frowned upon and tea-totalers are looked upon with suspicion. On the other hand, it is obvious that considerable alcohol intoxication is tolerated, condoned and even encouraged in many situations in North American society. When one considers the fact that these various attitudes are ultimately tied to, or interact with, the diverse pharmacological potentials of alcohol in determining the overall drug effect, the complexity of the psychopharmacology of the drug in North America becomes apparent. Because its use is so ingrained at all levels of society, there is a tendency for many Canadians not to even consider alcohol a drug.

C. Short-Term Effect

Alcohol exerts its more significant effects through the central nervous system, usually producing a general sedation or depression of neural activity over a wide dosage range, although in certain

circumstances, considerable behavioral and psychological arousal may result. Much depends to a large extent on the individual and the situation in which the drinking occurs. A drink or two may produce drowsiness and lethargy in some instances, while the same quantity might lead to increased activity and psychological stimulation in another individual, or in the same person in different circumstances. In many social settings, alcohol seems to result in a lessening of inhibitions and a feeling of well-being, sociability and camaraderie in most individuals. For many people alcohol relieves tension and anxiety -- the common notion that one 'needs a drink' when worried, irritated or upset, reflects a general acknowledgement of this function. Although alcohol usually elevates mood at first, a general lack of emotional control including anxiety, withdrawal, self-pity and depression may occur later. Alcohol has been frequently cited as an important contributing factor in many suicides.

The intensity of the acute effects of alcohol can, to a certain extent, be predicted from the amount of alcohol in the blood, although the relationships between the quantity of alcohol present and the central nervous system (CNS) response may vary considerably from individual to individual.

D. Long-Term Effects

Many authorities differentiate between 'low risk' (moderate) and 'high risk' (heavy) drinking in discussing the long-term effects

of alcohol. For most otherwise normal individuals, moderate drinking over a prolonged period of time may produce little significant psychological or physiological change. High risk or heavy drinking, e.g. five or six or more drinks a day, may lead to a variety of disorders, however, many of which are subsumed under the general term of 'alcoholism.'

E. Alcoholism

There is considerable disagreement among authorities as to the proper delineation of the concept of alcoholism - definitions may be as general as "a family of disorders accompanying chronic heavy drinking" with various social and economic complications, or may contain more restrictive specifications of physical dependency or psychological and physiological harm. In some areas of North America, at least two percent to five percent of alcohol users become alcoholics and many more would be considered problem drinkers.

F. Pathology

Frequently observed among alcoholics are disorders of the digestive tract, cardiovascular system, lungs, kidney, pancreas and the nervous system, with sleep disturbance and various kinds of irreversible neurological damage and cerebral atrophy. Alcohol is considered to be a major contributing or causal factor in liver cirrhosis. They may also develop a variety of other disorders which may result in

an increased susceptibility to other diseases and infection.

Many of these pathologies are considered to be of secondary origin - often a function of chronic dietary deficiencies, poor personal care and other aspects of the general life style which may accompany alcoholism. Proper diet and medical care may be able to prevent or alleviate many, but not all, of the problems associated with chronic alcoholism.

G. Tolerance

Tolerance to most of the effects of alcohol develops with frequent use - not, however, to the same degree or rapidity as with opiate narcotics. Regular heavy drinkers may be able to consume two or three times as much alcohol as a novice. Most intermittent or moderate drinkers show little tendency to increase dose, although regular heavy drinkers may, in order to obtain the desired psychological effects, ingest quantities which lead to chronic alcohol toxicity symptoms. In some alcoholics, tolerance later seems to decline and a special response or oversensitivity to certain effects of alcohol develops. In such individuals, even a single drink may produce profound loss of control and initiate unrestricted further indulgence.

H. Physical Dependence

Physical dependence on alcohol occurs in some long-term heavy drinkers after the development of tolerance. Physiological dependence

does not occur until after three to fifteen or more years of heavy consumption. Some heavy drinkers never become physically dependent on alcohol.

The overall picture of the alcohol withdrawal syndrome is generally similar to that for barbiturates. Nausea, anxiety, severe agitation, confusion, tremors, and sweating are followed by cramps, vomiting and illusion, and hallucinations. After several days, delirium tremors may develop and convulsion, exhaustion and cardiovascular collapse may occur. Major recovery in those surviving usually occurs within a week, although certain psychological symptoms may continue for a longer period.

I. Psychological Dependence

Psychological dependence on alcohol seems to occur in many individuals and such dependence appears to be generally accepted in contemporary North America. A great number of people regularly turn to alcohol for relief or aid prior to or after facing a stressful situation, to escape worries, trouble or boredom, to relax and enjoy a party, or even to sleep, and many feel they do not function as well in certain situations without a drink or two. There would appear to be a strong psychological component in the drinking behavior of the developing alcoholic, as is exemplified in the usually compulsive nature of his drinking and his frequent inability to control his use of alcohol in spite of obvious consequences.

J. Patterns of Drinking

Our culture is a drug-using culture. The majority of us are multiple drug users - coffee, tea, cigarettes, alcohol, tranquilizers, and so on. While it is difficult to draw any clear cut distinctions suitable for all approaches to use, misuse, and abuse, different types of users may be distinguished.

The following classification is adapted from the Second Report of the National Commission on Marijuana and Drug Abuse, United States, 1973 (pp. 30-32).

1. Experimental

The most common type of drug-using behavior, a short-term, non-patterned use of one or more drugs which may or may not continue. This type is motivated primarily by curiosity or a desire to alter mood. This type is found mainly among young persons.

2. Recreational

Recreational use occurs in a social setting among friends who have a wish to share, to interact, to enjoy themselves in an environment which is defined as both acceptable and pleasurable. This type of use is normally voluntary and does not usually escalate into a more intense use pattern. This is the major type of pattern among users of socially accepted drugs.

3. Circumstantial

This behavior is generally motivated by the user's perceived need or desire to achieve a new and anticipated effect in order to cope with a specific problem, situation or condition of a personal or vocational nature. E.g. executives, employees, housewives who seek to relieve tension, anxiety, boredom or other stresses through the use of sedatives or stimulants.

4. Intensified

In general this refers to drug use which occurs daily and is motivated by an individual's perceived need to achieve relief from a persistent problem or a stressful situation. Included here are the "problem drinkers" or "heavy social drinkers."

5. Compulsive

A use which consists of a patterned behavior at a high frequency and high level of intensity, characterized by a high degree of psychological dependence and perhaps physical dependence as well. The distinguishing feature of this behavior is that drug use dominates the individual's existence, and pre-occupation with drug taking precludes other social functioning. Examples of this type of user are chronic alcoholics and heroin-dependent persons.

The majority of drug users fall into the experimental and recreational type of users. A growing number of the adult population are circumstantial users - especially the tranquilizer pattern.

Other factors, often more important than the drug itself, that must be considered are the dose-taken, the mode of administration (smoking, inhaling, intravenously or intramuscularly), the feelings and emotional state of the individual, the expectation of drug used, and the environment in which the drug is taken.

APPENDIX II

Table 1

The Proportion of Users of Alcoholic Beverages, and of
Total Abstainers in Various Segments of the Population
According to a Survey Conducted in Ontario 1969

Population Characteristics	Number of Respondents*	Users (%)	Abstainers (%)
	1,891	79.7	20.3
<u>Sex</u>			
Male	875	85.7	14.3
Female	1,016	74.6	25.4
<u>Age</u>			
15-19	150	58.7	41.3
20-29	393	90.8	9.2
30-49	724	88.5	11.5
50 and Older	595	67.2	32.8
<u>Nativity</u>			
Foreign Born	567	85.4	14.6
Native Born	1,323	77.4	22.6
<u>Religion</u>			
Jewish	30	80.0	20.0
Catholic	573	84.6	15.4
Protestant	1,060	76.3	23.7
Other	94	68.1	31.9
No Religious Preference	126	96.0	4.0
<u>Income</u>			
Under \$5,000	426	68.3	31.7
\$5,000 - \$9,999	784	84.2	15.8
\$10,000 Plus	458	88.2	11.8
<u>Education</u>			
Grade 8 and Under	534	73.6	26.4
Grades 9-13	919	81.3	18.7
Over Grade 13	398	85.7	14.3
<u>Occupation</u>			
Professional & Managerial	240	86.7	13.3
Clerical and Sales	290	87.9	12.1
Skilled and Unskilled Labour	530	86.4	13.6
Farmers	28	82.6	17.9
Other (Not in Labour Force)	797	70.5	29.5
<u>Size of Community</u>			
Under 10,000	364	70.9	29.1
10,000 - 100,000	1,019	80.8	19.2
Over 100,000	508	84.8	15.2

*The "No Response" cases were deducted from the population.

Source: Annual Report 1971-72, Alcoholism and Drug Addiction Foundation.
An Agency of the Province of Ontario.

Table II

Dollar Sales and Apparent Consumption of Beverage Alcohol 1970*

Province	Thousands of Dollars of Sales of:			
	Beer	Wine	Spirits	Total
Newfoundland	20,933	964	13,956	35,853
Prince Edward Island	3,505	541	5,040	9,086
Nova Scotia	27,633	4,624	31,271	63,528
New Brunswick	20,249	3,790	20,121	44,160
Quebec	185,693	42,012	162,324	390,029
Ontario	267,693	55,336	324,421	647,450
Manitoba	38,015	6,380	40,632	85,027
Saskatchewan	32,770	5,593	34,650	73,013
Alberta	55,179	12,543	72,766	140,488
British Columbia	76,002	22,179	107,697	205,878
Canada	727,672	153,962	812,878	1,694,512

Province	Thousands of Gallons of Alcohol in:			
	Beer	Wine	Spirits	Total
Newfoundland	248.5	10.6	147.6	406.7
Prince Edward Island	52.0	9.0	54.8	115.8
Nova Scotia	439.5	77.1	339.6	856.2
New Brunswick	297.5	65.4	204.0	566.9
Quebec	4,933.4	690.1	1,853.6	7,477.1
Ontario	6,158.8	937.1	3,911.6	11,007.5
Manitoba	738.6	127.0	468.0	1,333.6
Saskatchewan	588.6	109.1	396.4	1,094.1
Alberta	1,196.2	258.1	791.6	2,245.9
British Columbia	1,665.3	445.4	1,351.6	3,462.3
Canada	16,318.4	2,728.9	9,518.8	28,566.1

*Figures based on data in: The Control and Sale of Alcoholic Beverages in Canada: Fiscal Year Ended March 31, 1970 (Dominion Bureau of Statistics, Ottawa). To convert gallons of beverage to gallons of absolute alcohol the following average values were employed: beer 5% alcohol by volume; wine 16%; spirits 40%.

Table III

Sales and Apparent Consumption of Beverage Alcohol per
Capita Related to Personal Disposable Income Per Capita
and Per Cent Urban Population 1970*

Province	Population Aged 15 and Older	Dollar Sales per Cap. of 15 & Older	Personal Inc. per Cap. of 15 & Older	Gals. Alcohol per Cap. of 15 & Older	% of Urban Population
Newfoundland	323,000	111.0	2,436.5	1.26	51
Prince Edward Island	74,700	121.6	2,516.7	1.55	32
Nova Scotia	527,300	120.5	3,015.4	1.62	54
New Brunswick	419,400	105.3	2,863.6	1.35	46
Quebec	4,194,900	93.0	3,347.2	1.78	74
Ontario	5,392,600	120.1	4,000.3	2.04	77
Manitoba	691,100	123.0	3,536.4	1.93	64
Saskatchewan	649,800	112.4	2,928.6	1.68	43
Alberta	1,081,000	130.0	3,744.7	2.08	63
British Columbia	1,527,700	134.8	3,692.5	2.27	73
Canada	14,881,500	113.9	3,589.4	1.92	70

*Estimates of personal disposable income per capita were calculated on the basis of data in: National Accounts: Income and Expenditure, 1970 (Dominion Bureau of Statistics, Ottawa). It should be noted that the income figures reported for any given year are subject to revision in the reports for subsequent years. Percentages of population classed as 'urban' were based on the figures for rural-urban distribution in the census of Canada, 1961. Estimates of 1970 populations by age were obtained from: Estimated Population by Sex and Age Group for Canada and the Provinces, 1970 (Dominion Bureau of Statistics, Ottawa).

Table IV

Percentage Contribution of Each Beverage to the Apparent Total
Alcohol Consumption and Total Alcohol Consumption per capita
1970*

Province	Beer	Wine	Spirits	Gals. of Alcohol Per Capita Aged 15 Years and Older
Newfoundland	61%	3%	36%	1.26
Prince Edward Island	45	8	47	1.55
Nova Scotia	51	9	40	1.62
New Brunswick	52	12	36	1.35
Quebec	66	9	25	1.78
Ontario	56	8	36	2.04
Manitoba	55	10	35	1.93
Saskatchewan	54	10	36	1.68
Alberta	53	12	35	2.08
British Columbia	48	13	39	2.27
Canada	57	10	33	1.92

*Figures were based on data in: The Control and Sale of Alcoholic Beverages in Canada: Fiscal Year Ended March 31st, 1970 (Dominion Bureau of Statistics, Ottawa). To convert gallons of beverage to gallons of absolute alcohol, the following average values were employed: beer - 5% alcohol by volume; wine - 16%, spirits - 40%.

Table V

Estimates of the Prevalence of Hazardous Alcohol Consumption 1970*

Province	Drinking Population	Number	Consumers of Hazardous Amounts
			% of Drinking Population
Newfoundland	258,400	8,450	3.27
Prince Edward Island	59,800	2,500	4.20
Nova Scotia	421,800	18,800	4.46
New Brunswick	335,500	11,900	3.54
Quebec	3,355,900	169,100	5.04
Ontario	4,314,100	262,300	6.08
Manitoba	552,900	31,200	5.65
Saskatchewan	519,800	24,500	4.71
Alberta	864,800	53,900	6.23
British Columbia	1,222,200	86,200	7.05
Canada	11,905,200	668,850	5.58

*A number of studies indicate that persistent consumption exceeding 10 centilitres of absolute alcohol per day is associated with increased risk of organic diseases such as liver cirrhosis. Ten centilitres is the amount of alcohol in a little less than 9 oz. of whiskey, or 21 ounces of wine (at 16% alcohol by volume) or 5½ (12 oz.) bottles of beer. It should be stressed that reference is to the total intake over a year expressed, for illustrative purposes, as an average consumption per day. In practice, the hazardous consumption may or may not occur on an equitable daily basis. Estimates of the number of drinkers consuming over the 10 centilitres level were obtained by means of the Ledermann Formula. (For a demonstration of its applicability to Canadian data see: de Lint J. and Schmidt, W., The Distribution of Alcohol Consumption in Ontario, Quart. J. Stud. Alc. 29: 968-973, 1968.) Drinking populations were based on the finding in a recent survey that 80% of persons aged 15 years and older reported use of alcoholic beverages in some degree.

Table VI

Deaths from Liver Cirrhosis 1969 and Estimates
of the Prevalence of Alcoholism 1968*

Province	Deaths from Liver Cirrhosis			Alcoholism Prevalence	
	Total Deaths	Per 100,000 Aged 20 and Older	Per 1,000 Deaths from All Causes	Total Alcoholics	Alcoholics per 100,000 Aged 20 and Older
Newfoundland	13	5.1	4.3	3,800	1,500
P.E.I.	5	8.1	5.0	1,100	1,800
Nova Scotia	47	10.6	7.1	7,400	1,700
New Brunswick	32	9.3	6.6	5,800	1,700
Quebec	475	13.5	11.8	98,700	2,900
Ontario	644	14.2	11.6	130,300	2,900
Manitoba	63	10.7	7.8	13,000	2,200
Saskatchewan	56	10.0	7.5	10,000	1,800
Alberta	97	10.8	9.8	18,100	2,100
British Columbia	212	16.5	12.2	38,700	3,100
Canada	1,644	13.1	10.7	326,900	2,700

*Figures for liver cirrhosis were based on data in: Vital Statistics: Final Report 1969 (Dominion Bureau of Statistics, Ottawa). Estimates of alcoholism prevalence were obtained by means of the Jellinek Formula which infers the probable cause of alcoholics in a population from the centred two year moving average of total reported liver cirrhosis mortality. Although the method is open to question from many points of view, studies to date indicate that it is more likely to under-estimate than to over-estimate the prevalence in a given area. Furthermore, confidence in its applicability to Canada localities has been increased as a result of the close agreement found between estimates based upon it and the results of two direct surveys of an Ontario county, conducted under the auspices of the Foundation. For detailed discussion of the nature and validity of the method see: Popham, R.E. The Jellinek Alcoholism Estimation Formula and its Applications to Canadian Data (Quarterly Journal Studies on Alcohol 17:559-93, 1956.)

Table VII

First Admissions for Alcoholics and for All Causes to Mental Institutions 1969*

Province	Aged 20 § Older	Alcoholics with Psychosis	Alcoholics without Psychosis	Total Alcoholism	Alcoholics per 100,000 Aged 20 § Older	All Causes	All Causes per 100,000 All Ages	Percentage Alcoholics Among All Causes
Newfoundland	257,000	9	41	50	19.5	538	105	9.3
Prince Edward Island	62,100	7	64	71	114.3	268	244	26.5
Nova Scotia	442,100	32	392	424	95.9	2,155	282	19.7
New Brunswick	345,100	20	238	258	74.8	1,212	194	21.3
Quebec	3,516,600	134	2,527	2,661	75.7	11,194	187	23.8
Ontario	4,550,900	333	2,469	2,802	61.6	19,367	260	14.5
Manitoba	590,300	84	243	327	55.4	2,750	281	11.9
Saskatchewan	558,800	27	88	115	20.6	1,363	142	8.4
Alberta	896,500	60	471	531	59.2	3,612	231	14.7
British Columbia	1,283,800	66	462	528	41.1	3,949	191	13.4
Canada	12,503,200	772	6,995	7,767	62.1	46,408	221	16.7

*Figures were based on data in: Mental Health Services, 1969 (Dominion Bureau of Statistics, Ottawa).

Table VIII

Convictions for Offences Involving Alcohol and for All Types of Offences 1969¹

Province	Convictions for Drunkenness ²			Other Convictions under the Liquor Control Act ²	Convictions for Drunken Driving	Convictions for Impaired Driving	Convictions for All Types of Offence ²
	Male	Female	Total				
Newfoundland	954	42	996	781	17	409	25,298
Prince Edward Island	1,271	12	1,283	1,186	3	216	7,344
Nova Scotia	7,649	215	7,864	4,292	1	1,251	43,334
New Brunswick	5,142	178	5,320	6,648	16	1,438	28,279
Quebec	---	---	---	---	11	3,621	---
Ontario	49,919	4,446	54,365	48,798	615	13,175	1,193,099
Manitoba	7,443	1,544	8,987	7,991	271	1,336	112,844
Saskatchewan	3,558	726	4,284	11,427	98	1,427	92,706
Alberta	14,738	1,757	16,495	23,393	78	3,327	152,591
British Columbia	1,315	94	1,409	4,825	148	4,950	208,542
Canada	91,989	9,014	101,003	109,341	1,258	31,150	1,864,037

¹ Figures were taken from: Statistics of Criminal and Other Offences, 1968 (Dominion Bureau of Statistics, Ottawa).

² On January 1st, 1968, a new reporting system was implemented in the Province of Quebec through the collaboration of the Dominion Bureau of Statistics in Ottawa and the Quebec Department of Justice. Though data is available for offences under the Criminal Code, there is none available for offences under the Federal Statutes, Provincial Statutes or Municipal By-Laws. Under the Criminal Code, the Province reported "no convictions" for "Causing a Disturbance by Being Drunk" on Summary Conviction, Totals for Canada, on these columns will not include the Province of Quebec.

Table IX

Conviction Rates 1968¹

Province	Per 100,000 Population 15 yrs. & Older ²			Per 100,000 Vehicles	
	Drunkenness	Other Offences Under the LCA's	All Types of Offence	Drunken Driving	Impaired Driving
Newfoundland	323	254	8,214	16	378
P.E.I.	1,750	1,618	10,019	8	581
Nova Scotia	1,531	836	8,436	----	468
New Brunswick	1,302	1,627	6,919	8	725
Quebec	-----	-----	-----	1	192
Ontario	1,072	962	23,523	21	459
Manitoba	1,336	1,188	16,780	71	351
Saskatchewan	660	1,761	14,284	21	308
Alberta	1,633	2,317	15,111	11	473
British Columbia	100	341	14,754	16	526
Canada	998	1,080	18,418	16	395

¹Numbers of registered motor vehicles were obtained from: The Motor Vehicle, Part 3: Registrations 1968 (Dominion Bureau of Statistics, Ottawa). The category includes passenger cars, commercial vehicles, and motorcycles. Rates for the year 1968 are the most recent available.

²Rates for "Canada" are based on the total population of Canada aged 15 years and older excluding the Province of Quebec (see footnote 2, Table VIII) and the Yukon and Northwest Territories.

Table X

Selected Characteristics of the Alcoholic Population*

Characteristics	Per Cent
<u>Sex</u>	
Male	84.3
Female	15.7
<u>Age</u>	
Under 20	1.1
20-29	10.0
30-39	20.7
40-49	29.0
50-59	21.1
60 and Older	13.9
Unknown	4.2
<u>Marital Status</u>	
Single	18.4
Married	55.7
Common-Law	1.7
Separated	13.8
Divorced	1.7
Widowed	5.7
Unknown	3.1
<u>Education</u>	
No Schooling	0.3
Kindergarten - Grade 8	24.7
Grade 9 - 13	15.9
Over Grade 13	3.1
Unknown	55.9
<u>Occupation</u>	
Professional and Technical	2.1
Managerial and Proprietary	8.8
Clerical and Sales	7.1
Service and Recreation	10.6
Transport and Communication	3.9
Farmers and Farm Workers	4.0
Craftsmen and Production Workers	16.9
Loggers, Miners, Quarrymen	0.3
Unskilled Labourers (Other than those included above)	26.0
Housewives	8.9
Retired, Pensioned and Unemployable	7.6
Not in Labour Force	0.8
Unknown	2.7
<u>Residence</u>	
Rural	23.8
Urban	74.8
Unknown	1.4

*Based on the results of a case-finding survey of alcoholism in Frontenac County, Ontario. The data pertain to an alcoholic population of 1,245 in the year 1961.

APPENDIX III

Alberta Liquor Control Board Sales for Northern Alberta, 1970, 1971, 1972 & 1973

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	Total Sales (Liquor & Beer) For Year Ended March 31, 1970	Increase or Decrease	1971	Increase or Decrease	1972	Increase or Decrease	1973	Increase or Decrease
CENSUS DIVISIONS 12, 13, 14, 15								
GRAND TOTALS	\$ 12,469,279	+ 8.88% of Alberta Total	\$ 13,324,341	+ 6.42 + 8.47% of Alberta Total	\$15,643,100	+14.82 + 8.74 of Alberta Total	\$ 18,999,246	+17.66 + 9.34% of Alberta Total
ALBERTA TOTALS	\$140,488,410		\$156,391,206	+10.16	\$178,953,025	+12.60	\$203,516,205	+12.06

Census Division 12

Census Division 12	Total Sales (Liquor & Beer) For Year Ended March 31, 1970	1971 Increase or Decrease	1972 Increase or Decrease	1973 Increase or Decrease
Bonnyville	\$ 375,856	\$ 371,410 - 1.18	\$ 419,621 +12.98	\$ 481,136 +12.79
Cold Lake	592,958	650,004 + 8.78	792,847 +18.02	921,580 +13.97
Elk Point	154,914	146,641 - 5.3	168,907 +13.18	204,978 +17.16
Fort McMurray	598,007	683,432 +12.5	852,124 +19.8	1,015,012 +16.05
Glendon		33,121	109,500 +69.75	134,800 +18.77
Lac La Biche	312,424	337,601 + 7.46	370,609 + 8.91	414,902 +10.68
St. Paul	581,079	596,685 + 2.62	651,214 + 8.37	764,380 +14.8
Vilna	150,865	156,435 + 3.56	174,146 +10.17	197,862 +11.99
TOTAL	\$2,766,103	\$2,975,329 + 7.03	\$3,538,968 +15.93	\$4,134,650 +14.41

Census Division 13

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Census Division 13	Total Sales (Liquor & Beer) For Year Ended March 31, 1970	1971 Increase or Decrease	1972 Increase or Decrease	1973 Increase or Decrease
Athabasca	\$ 338,794	\$ 342,674 + 1.13	\$ 392,412 +12.67	\$ 482,274 +18.638
Barrhead	401,321	408,726 + 1.84	463,535 +11.82	571,850 +18.94
Boyle	210,138	211,530 + .66	240,104 +11.9	250,853 + 4.28
Mayerthorpe	193,025	198,220 + 2.62	213,831 + 7.3	258,271 +17.20
Redwater	253,568	272,166 + 6.83	302,975 +10.16	250,758
Thorhild				233,284
Westlock	514,831	528,801 + 2.642	581,227 + 9.02	682,025 +14.77
TOTAL	\$1,911,677	\$1,962,117 + 2.57	\$2,194,084 +10.57	\$2,729,315 + 8.13

Census Division 14

Census Division 14	Total Sales (Liquor & Beer) For Year Ended March 31, 1970	1971 Increase or Decrease	1972 Increase or Decrease	1973 Increase or Decrease
Edson	\$ 625,109	\$ 714,749 +12.54	\$ 767,898 + 6.92	\$ 803,687 + 4.45
Evansburg	199,379	209,957 + 5.03	233,464 +10.06	295,808 +21.07
Hinton	478,681	513,738 + 6.82	593,489 +13.43	713,230 +16.78
Whitecourt	419,477	441,139 + 4.91	480,076 + 8.11	484,128 + .83
TOTAL	\$1,722,646	\$1,879,583 + 8.35	\$2,074,927 + 9.41	\$2,296,853 + 9.66

Census Division 15	Total Sales (Liquor & Beer) For Year Ended March 31, 1970	1971 Increase or Decrease	1972 Increase or Decrease	1973 Increase or Decrease
Beaverlodge	\$ 161,321	\$ 177,699 + 9.21	\$ 213,309 +16.69	\$ 267,001 +20.10
Fairview	262,030	274,347 + 4.49	331,351 +17.20	425,508 +22.12
Falher	201,666	207,641 + 2.87	237,196 +12.46	294,194 +19.37
Fox Creek				197,344
Grande Cache	169,001	233,378 +27.58	308,081 +24.24	352,013 +12.48
Grande Prairie	1,814,778	1,939,617 + 6.43	2,439,433 +20.48	3,245,105 +24.82
Grimshaw	201,417	195,158 - 3.1	219,995 +11.29	253,384 +13.17
High Level	383,312	461,852 +17.00	548,272 +15.76	595,839 + 7.98
High Prairie	357,577	374,960 + 4.63	489,180 +23.34	638,844 +23.42
Manning	205,420	205,147 - 1.3	226,475 + 9.42	243,650 + 7.05
McLennan	93,045	95,513 + 2.58	102,077 + 6.43	105,275 + 3.03
Peace River	1,179,889	1,223,135 + 3.53	1,376,862 +11.16	1,603,705 +14.14
Slave Lake	335,892	360,335 + 6.78	427,677 +15.74	591,320 +27.67
Spirit River	241,362	260,067 + 7.19	299,117 +13.05	333,232 +10.23
Swan Hills	98,561	150,862 +34.66	230,579 +34.57	256,379 +10.06
Valleyview	363,582	347,601 - 4.4	385,517 + 9.8	435,635 +11.50
TOTAL	\$6,068,853	\$6,507,312 + 6.74	\$7,835,121 + 6.95	\$9,838,428 +20.36

APPENDIX IV

AADAC Facilities in Northern Region

Alberta Alcoholism and Drug Abuse Commission - NORTHERN REGION

North Regional Office - #B1, 10405 - 100 Avenue, Edmonton, Alberta
424-0392

North Region Director
Community Services Supervisor
Secretary

Grande Prairie - #202 Nordic Court, Grande Prairie, Alberta
532-0500

Counsellor
Counsellor
Secretary

Fort McMurray - Box 5654, Fort McMurray, Alberta
743-8353

Counsellor
Secretary

St. Paul - Box 1576, St. Paul, Alberta
645-3397

Counsellor

Slave Lake - Box 133, Slave Lake, Alberta
849-2281

Counsellor

High Prairie - Box 446, High Prairie, Alberta
423-3303

Counsellor

Peace River - c/o Peace River Correctional Institute, Peace River, Alberta
624-5480

Counsellor

High Level - Box 1161, High Level, Alberta
926-3791

Counsellor

June 10, 1974

DIRECTION FOR NORTHERN REGION, AADAC

Wm. Henry, North Region Director

Under the Commission Mandate, we have basically three areas of concern: Prevention or Educative Community Development, Treatment Rehabilitation, and Impaired Drivers' Program.

I would like to deal with each one of these separately and quite briefly.

Prevention or Educative Community Development

My impression of this function is to develop community awareness about the Alcoholism Drug Abuse problems through a community development education program. To achieve this end, I have initiated the establishment of a community education component within the region. This component will be responsible for the development of a Regional Educational Program, providing backup to the staff in each of the geographical areas of the region. Mr. R. Frederick will be the first staff person placed in this component and the initial development of the above mentioned program will be his responsibility. Each of the Northern Region staff also have responsibilities in these areas in developing interest in Seminars and Educative Programs in their areas and, in some cases, conducting these programs and assisting Mr. Frederick in his presentations at various seminars and educative programs that he will conduct in each of these geographical areas.

Treatment Rehabilitation

Regionally, I feel now that it is time for the Commission to become quite active in the treatment rehabilitation areas. I do not believe that the North Region staff can assume the total caseload in each area, so it is my opinion that a consultative and developmental role with community agencies is very important. Hopefully, getting them to assume some responsibility for treatment. The other area of concern is follow-up from AADAC treatment facilities. Each counsellor will have to become involved in this area, again not necessarily doing all the follow-up, but arranging for follow-up in their respective areas with local counselling agencies.

It would be expected that each counsellor would assume the responsibility for a small to reasonably sized active counselling caseload. The formulation of groups for therapy purposes I also feel are very important. I would suggest starting with the information group series and continuing on into group therapy practices, as this will enable us to handle a maximum caseload with a minimum staff house being expended.

There will be staff positions opening in areas such as Peace River, High Level, Fort McMurray, and St. Paul. With the advent of the Impaired Driving Program which I will deal with further on, we can reasonably expect about one-third of the total number taking the Impaired Drivers' Program to end up in a treatment modality. This is in addition to normal referrals, walk-in business, etc. As a result, co-ordination of staff time is a very important factor and would be the responsibility of myself and each staff member.

Impaired Driver's Program

This program is established in a number of areas in the north region to date with reasonable expectations of it growing and becoming common place across the region as we have requests from the judiciary in various areas in the region now. This will undoubtedly be an additional load on staff members, discounting the treatment factor that is to be expected. Just the presentation of this program is time consuming, and requires a fair amount of background work. As you are all no doubt aware, with the geographic area to cover in the north region, the conducting of the various programs under the Commission Mandate is going to be far more difficult than in any area in the Province of Alberta to date. Another consideration is the cost of operation, which needless to say, is quite extensive and again I would wish to emphasize the importance of good area and time planning. In short, try to arrange your Educative and Impaired Drivers' programs so that they coincide as much as possible.

APPENDIX V

Recommendations made by the late Wm. Wacko, Alcohol and Drug Consultant, Department of Indian Affairs and Northern Development, Alberta Region, August 1, 1973 and November 4, 1974.

RECOMMENDATIONS AND PROPOSED PROGRAMME

I. Alcohol Availability and Enforcement of Liquor Ordinances

1. RECOMMENDED - that Government regulations and programming be aimed at reducing the pattern of drinking which leads to drunkenness. Toward this end some possible measures might be:
 - a) Making available and encouraging use of weak beers.
 - b) Making food easily available on drinking premises.
 - c) Making non-alcoholic drinks available and not penalizing those who use them by regulation or innuendoes of serving staff.
 - d) Encouraging recreational activities within licensed premises, so that sociability and physical movement is enhanced and accepted and social sanctions against drunkenness increased.
 - e) Encouraging and supporting recreational and sport facilities where alcohol is not served. Northwest Territories appears to be the only place where alcohol is served at bingo games.
 - f) Printing warnings on bottles and cartons of alcoholic beverages such as: "Warning: Alcohol is a drug and excessive use may be injurious to your health." Also warnings could be posted in drinking premises - and be in Eskimo syllabics where appropriate.
 - g) Training, and perhaps licensing of bar managers in respect to Government ordinances, liabilities of licensee as well as elementary knowledge of alcohol and alcoholism.
 - h) Providing a breathalyzer or other less expensive devices which could be used by the customers to determine the degree of their intoxication, and also serve as an educational tool in respect to hazardous amounts of alcohol.
2. RECOMMENDED - that the liquor ordinances of Northwest Territories have included in them not only a clear statement about the responsibilities of licensees, especially in respect to not serving minors and those apparently intoxicated, but also should include a civil liability section. This section would partially meet many people's concern about the irresponsible profit making motives of those in the alcoholic beverage industry.

Experience in the southern provinces has been in the direction of laying greater onus on those selling alcohol beverages, as noted for example in the Ontario Act and the recent decision of the Supreme Court of Canada. This civil liability clause may appear onerous, but in the interest of prevention of offences and saving of lives, is necessary and warranted. There was general agreement among the interviewees and those specializing in this area that licensee infractions had to be dealt with firmly by such measures as the closure of business for significant periods of time, rather than by inconsequential fines. To clarify and strengthen the liability section of the Ontario Act, the following revised wording is being proposed:

"Where any person, or his servant or agent, sells liquor to or for a person whose condition is such, that the consumption of liquor would apparently intoxicate him, or increase his intoxication so that he might be in danger of causing injury or damage to his person or damage to his property, or causing injury or damage to the person or the property of others, then if the person to or for whom the liquor is sold, while so intoxicated:

- a) causes injury to himself or damage to his own property, or is himself injured by another or others, or suffers damage to his property by another or others, then in any of those cases, any person so injured in his person or property is entitled to bring an action for damages against the person, persons or corporations who, or whose servants or agents, sold the liquor:
- b) causes injury or damage to the person or property of another person or corporation, then any person or corporation so injured in his person or property is entitled to bring an action for damage against the person, persons or corporations who, or whose servants or agents sold the liquor:
- c) commits suicide or meets death by accident, actions under the Fatal Accidents Act or under the Trustee Act lie against the person, persons, or corporations who or whose servants or agents sold the liquor."

3. RECOMMENDED - that R.C.M.P. be delegated the responsibility of enforcing the liquor ordinances pertaining to licensed premises. R.C.M.P. policing of licensed premises would have the following advantages:

- Police are available in every community where drinking establishments operate.
- The policing would be two-fold - of the licensee and the customer. Such policing, in uniform and where necessary without uniform, would assure that minors and intoxicated customers would not be served.
- Experience of some police officers suggests that such a police presence could be a preventive factor forestalling violence or injury or crime after the bar closes.

The above approach has been successfully operating in Ontario and is being considered in Alberta.

In all cases a co-operative team approach would be most desirable; co-operation and good communication between the licensee and the liquor inspector and the liquor board; between the licensee and the police force; between the police force and the alcoholism program personnel.

4. RECOMMENDED - that more use be made of innovative procedures for alcohol distribution to allow for greater Native involvement in the control of alcohol use and consequences of alcohol abuse.

Any such experimentation would require considerable preparation of the community as a whole as well as those charged with specific responsibilities. New thinking needs to be explored where certain Native groups may wish to develop licensed establishments within the context of their own culture.

5. RECOMMENDED - that in order to lessen the damaging effects on the Native communities along the Mackenzie, the Government consider:
 - a) operating, on an experimental basis, beer premises in which the motive is not profit, but recreation without drunkenness. This is similar to Recommendation of Northwest Territories Board of Liquor Inquiry in 1969;
 - b) imposing some responsibility on companies for the behavior of their men.

Periodic dumping of workmen on small communities should be avoided. Many of these men, loaded with money and need for sex outlets, harass the small communities, including young girls of thirteen and fourteen years of age. Transporting such workers directly to urban centres in the south would lessen the damage done to the northern communities. Experience of Hire North supports the credibility of this suggestion.

Native people of the north warrant a similar level of protection to that now accorded to northern ecology.

6. RECOMMENDED - that in order to provide more peer group sanctions of those committing alcohol offences or offences committed under the influence of alcohol, community Native people be involved in various ways by Justice personnel. Further, that such sentences be community oriented and where appropriate include sentencing to alcohol treatment facilities. Such sentences, within limits, could be of a minimum-maximum nature pending the kind of participation and involvement of the offender in the treatment program.

Going to jail for some people is not a social disgrace and may in fact be looked upon by the individual's peer group as a positive achievement. Therefore the need to make legal and justice procedures more meaningful and effective.

7. RECOMMENDED - that the Territorial Government set a good example to private industry in the North by establishing a Government policy on alcohol and drug abuse within the Government service.

Such a policy, similar to those in the Federal Government and in the other provinces, recognizes that people with alcohol or drug problems have a health problem and are eligible for treatment and disciplinary action if such treatment is not accepted.

Further, the Government may wish to:

- a) formally warn its employees that any intoxication while on duty will not be tolerated,
- b) establish training sessions for its supervisory staff as part of the proposed alcohol and drug program.

Additionally, the Government could, at its various social functions, ascertain by its actions and policies that drinkers of non-alcoholic beverages are not penalized or embarrassed. Of interest is the fact that a number of clergymen in the North have ceased drinking in public in order to set a different example to Natives than those they have come to associate with white men.

II. Community Resource Development

Whereas most problems arise at the community level, it is at this level that they must be coped with.

- Required - 1) Financial resources - to be met by grants-in-aid
- 2) Motivation & community teamwork - to be met and facilitated by members of Staff Task Force (one

at Yellowknife serving Fort Smith-Inuvik regions; one at Frobisher Bay serving Frobisher Bay and Churchill regions.)

- 3) Specialized skills and knowledge - to be met through summer school courses and community workshops.

In the words of one Native, "local people would really carry the ball- they would be like a cabinet - the resource man would be the technician."

Purpose of grants-in-aid programmes is assistance to local communities to do whatever appears logical to better understand and cope with local problems arising from the misuse of alcohol and other substances. A variety of community groups could apply. In some communities it may be the Settlement Councils or Indian Band Councils, or in others special community committees-of-concern - several of which are already functioning.

III. Evaluation and Research

With any programme there is danger of wastage of funds unless there is a critical and objective analysis of what is going on and whether the results appear consistent with goals.

Such assessment is basic to programme planning. Furthermore, it pays to learn from research and experiences of other programmes. The Evaluations and Research staff member could keep abreast of developments in other programmes and feed in this information to the Task Forces and through the Director of the programme to the Alcohol and Drug Abuse Co-ordinating Council.

IV. Native Intern Teaching

The role of Natives in the Task Force is for a twofold reason:

- a) for a two-way learning situation, that is, Natives are teachers as well as learners - they learn certain facts from "professionals" and "professionals" learn from the Natives of the ways and values of Native peoples;
- b) to prepare them to take over responsibility for certain components of the alcoholism programmes and to assume leadership and service responsibilities in the smaller communities throughout the North.

The dilemma of needing specialized skills, without permanently blocking appointments of Natives or other northern people could be resolved through arranging, where necessary, well remunerated two year contracts with southerners whose responsibility will include the training of their northern successors. Alternative approaches would include selection of northerners and their preparation for the senior positions.

RECOMMENDED - that greater investment be made in the development of the human resources of the North; that this development be more in terms of the psyche and the spirit; that such development be facilitated through grants to people; that since grants to Native political organizations for service programmes run the risk of "political" controversy and criticism, such grants could still be made to Native groups specifically organized for self-help and service purposes. Such purposes could include Native family counselling, Native court services, Native mental health and alcoholism prevention programmes.

The spirit of this last recommendation is basic to all recommendations - services are not really effective if they are not known, understood or trusted. "Give us grants and we will give you back twenty-five civil servants," are the words of one Native echoed by many others in a variety of ways. The Government has hundreds of whites taking care of Natives - a dependency relationship in which too often there is little love either way. Natives have become dependent on non-natives and now the non-natives have become dependent on the dependencies of the Natives. There are civil servants who respect Native people - have positive expectations and get positive results. But there appears to be many who, consciously or unconsciously, lack confidence in Native people -- have negative expectations and their negative expectations are fulfilled. The great need in the north is to stop destroying people by "taking care" of them. Rather their need appears to be for the freedom, opportunity and power to take care of themselves, and in so doing substantially reduce their alcohol related problems.

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